STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E680	A. BUILDING 01 B. WING	07/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HEALTH CARE	1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/22/11 Facility Number: 003624 Provider Number: 15E680 AIM Number: 200429840 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Providence Health Care was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original North/South wing was surveyed with Chapter 19, Existing Health Care Occupancies. This facility is located in two, one story buildings, the North/South	K0000	Submission for this plan of correction shall not constitute an admission by Providence Health Care, Inc. to the allegations contained in this survey report. Providence Health Care Inc. specifically and generally denies that the survey allegations are indicative of the quality of nursing care and service provided to residents of this health care facility. This plan of correction is submitted in accordance with the requrements of State and Federal law. We respectfully request paper compliance for this plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	and the East/West, connected by a thirty foot corridor. The buildings were determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident sleeping rooms. The facility has the capacity for 70 residents and had a census of 41 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/27/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:			
K0046 SS=C	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on record review and interview, the facility failed to provide documentation of 30 second periodic testing at 30 day intervals and annual testing for 1 1/2 hours for 2 of 2 battery powered emergency lighting fixtures. LSC 7.9.3 requires a functional test shall be conducted on every required battery powered	K0046	We have revised our inspection form to include the fact that the 30 second testing needs to be completed every month and annually tested for 90 minutes. We have placed a tickler on the electronic calendar of the computer of the Director of Environmental Services so that he will check and sign off on the fact that these tests have indeed been performed according to	08/12/2011

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	emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted for not less than 1 1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice could affect 23 residents on the north/south wing. Findings include: Based on review of facility fire safety inspection and test records with the environmental services supervisor and interim administrator on 07/22/11 at 2:15 p.m., the generator test records included spaces for documenting 30 second monthly as well as 1 1/2 hour annual tests for the two battery powered emergency lighting fixtures located in the power plant where the emergency generator for the north/south wing was housed. No entry for testing the lighting was entered since August 2010. At the time of record review, the interim administrator called the maintenance office and reported there was no other documentation of testing these light fixtures.		code.On August 2, 2011 from 2:30 p.m. to 4:00 p.m. Randy Cesinger tested the first light for 90 minutes, and on August 3, 2011 from 10:30 a.m. to 12:00 the second light was tested for 90 minutes, both according to code. (See attached documents).An inservice is scheduled for August	

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	3.1-19(b)			
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted on every shift during 2 of the past 4 quarters. This deficient practice affects all occupants on the north/south wing. Findings include: Based on a review of monthly Fire Drill Reports for the past year with the environmental services director and interim administrator on 7/22/11 at 1:30 p.m., fire drill documentation was not found for the first shift during the fourth quarter of 2010 or for the first, second and third shifts during the first quarter of 2011. The interim administrator said at the time of	K0050	We have enabled a monthly computer activiated alert system on the computer of the Manager of enviromental services and the computer of the office of the Assistant to the Administrator of Providence Health Care. This alert will activate each month on the 5th day of the month at which time the administrator and the manager of environmental services will check the fire drill longs and enusre they are in compliance for the required testings for all three shifts for their quarterly fire drills.In the event that neither of the aforeto mentioned persons would be available on the 5th day of any given month, prior arrangements will be made to forward the alert to an appropriate mangement staff person directly involved with Providence Healt Care and knowledgable of our proceedures for performing a fire drill.When all	08/02/2011

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	record review, there had been significant personnel changes and the drills had not been conducted. 3.1-19(b) 3.1-51(c)		fire drills have been fully executed on all three shifts the Manager of Environmental services will record said drills in the log book and notify the Administrator.	
K0051 SS=F	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6			
	Based on observation and interview, the facility failed to ensure 1 of 3 fire alarm panels in an area not continuously occupied was provided with automatic smoke detection to ensure notification of a fire at the location before it could be incapacitated by	K0051	We have contacted our fire alarm contractor, Simplex-Grinell, Indianapolis, IN. to come install an automatic smoke detection device in the entry vestibule of the north/south wing of Providence Health Care to ensure notification of a fire before the fire alarm panel which is not continuously occupied and/or monitored could	08/12/2011

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	fire. NFPA 72, 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in that location. This deficient practice affects all occupants. Findings include: Based on observation with the environmental services director on 07/22/11 at 2:35 p.m., an ancillary fire alarm control panel (FACP) was located in the entry vestibule of the north/south wing which was not continuously occupied and was not electrically supervised by a smoke detector. The environmental services director agreed at the time of observation, the panel was not continuously visible to staff. 3.1-19(b)		be incapacitated by fire. They are scheduled to do the work on Tuesday, August 9, 2011.Jim Brown, Director of Facilities Maintenance, will monitor the instilation and report to the Administrator when the work is completed.	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on interview and record	K0144	While we have been running load	08/19/2011

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	review, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems for the north/south wing. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all occupants of the north/south wing. Findings include:		tests according to our understanding of the code, and while more than sufficient for the load we pull in our small facility, they are not to the level of testing according to NFPA 110 which states that the load test must be run at 25 % of nameplate for 30 minutes, then at 50% for 30 minutes , followed by 75% for 60 minutes for a total of 2 hours. We have contacted Sycamore Engineering, of Terre Haute, IN., the contractor who performs this test for us, and have reqested that they conduct another load bank test according to NFPA 110. Facilities Maintenance Director, Jim Brown, will oversee this testing proceedure and document that it was tested according to the code requirements. He will also assure that the automated settings for our monthly testing be set so the generators can be exercised monthly for 30 minutes with the available load to meet federal certification and state licensure requirements.The NFPA 110 code for generator testing will be reviewed annually by the Facilities Maintenance Director, and the Health Care Administrator before the annual test is conducted to assure compliance to the code.A reminder to do so will be place on the computer of the Facility Maintenance Diector, the Health Facility Administrator, and the Executive Assistant to the Health Facililty Administrator.	

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	Based on review of the Monthly Generator Testing/Inspection records with the environmental services director and interim administrator on 07/22/11 at 2:10 p.m., the generator load on the north/south generator was less than 30 percent of the generator's load capacity during the monthly tests. (The load recorded for June 2011 was 13.7 percent.) In addition the test was documented: "run time completed: 25 (minutes) and "cool down completed: 10 (minutes)." Asterisks at the bottom of the records noted, "run generator for 30 minutes and then a fifteen (15) minute cool down period." At 2:50 p.m. on 07/22/11, the generator was tested with maintenance # 1 and started within two seconds. Maintenance # 1 said he documented every test of the generator for the facility and records reflected the actual readings. He also said a load test was done by an outside contractor because there was not enough load available to test the generator each month at 30 percent. A review of a load test done by the contractor dated 05/24/11 with			

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	the environmental services director and interim administrator on 07/22/11 at 2:10 p.m. noted the north/south generator was tested for 35 minutes under 34 percent load. The environmental services supervisor and interim administrator agreed at the time of review, 34 percent was not enough for a full load test. 3.1-19(b)			
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/22/11 Facility Number: 003624 Provider Number: 15E680 AIM Number: 200429840 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Providence Health Care was found	K0000	Submission for this plan of correction shall not constitute an admission by Providence Health Care, Inc. to the allegations contained in this survey report. Providence Health Care Inc. specifically and generally denies that the survey allegations are indicative of the quality of nursing care and service provided to residents of this health care facility. This plan of correction is submitted in accordance with the requrements of State and Federal law. We respectfully request paper compliance for this plan of correction.	

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	not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The East/West wing and therapy suite were surveyed with Chapter 18, New Health Care Occupancies. The East/West wing is connected by a thirty foot corridor to the north/south building. The facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident sleeping rooms. The facility has the capacity for 70 residents and had a census of 41 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:			

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	(111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident sleeping rooms. The facility has the capacity for 70 residents and had a census of 41 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:			
K0029 SS=E	Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure 2 of 5 hazardous areas in the east/west wing, such as soiled linen collection receptacles of more than 32 gallons within a 64 square foot area, were located in a room equipped with latching, self closing doors. Sprinklered hazardous areas are required to	K0029	After investigation we found that we have limited space anywhere else to store the soiled linen collection receptables and to stay in compliance we are going to install hydraulic self closing door hardware to the doors to the room where the soiled linens are kept. We have checked every place where we store soiled linens and clothing and have found there are only two such doors which need attention. All other said doors	08/19/2011

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	be equipped with self closing doors or with doors which close and latch automatically upon activation of the fire alarm system. This deficient practice a affects visitors, staff and 18 residents on the east/west wing. Findings include: Based on observation with the environmental services director on 07/22/11 between 11:20 a.m. and 12:30 p.m., two bathing rooms were used as collection sites for five, three bin soiled linen carts in which each bin had the capacity of 32 gallons. A 35 gallon gallon soiled linen receptacle was also stored in each bathing area. The bins were more than half full. The doors had no self closer and were each equipped with a deadbolt latch which had to be operated manually to engage and hold the door tightly closed. The environmental services director agreed at the time of observations, the doors did not meet the requirements for the materials stored in the rooms. 3.1-19(b)		have the proper closing equipment on them.On 8/1 Work orders were placed with the Facilites Management Office of the Sisters of Providence to address the self closing door hardware mechanisms of both the East and West Shower/Bathing areas. Puchase orders have been obtained and according to shipment sheduling of the parts the hydrolic self closing hardward will be installed on the doors no later than 8/19/11. These items have been placed on the priority list to be completed by 8/19/11.Environmental services Director, Dave Kable, will be monitoring to make sure the self closing hardware for the doors is installed and report back to the Administrator at that time.	

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K0046 SS=C	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 Based on record review and interview, the facility failed to provide documentation of 30 second periodic testing at 30 day intervals and annual testing for 1 1/2 hours of 2 of 2 battery powered emergency lighting fixtures. LSC 7.9.3 requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted for not less than 1 1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice could affect 18 residents on the east/west wing. Findings include: Based on review of facility fire safety inspection and test records with the environmental services supervisor and interim administrator on 07/22/11 at 2:15	K0046	We have revised our inspection form to include the fact that the 30 second testing needs to be completed every month and annually tested for 90 minutes. We have placed a tickler on the electronic calendar of the computer of the Director of Environmental Services so that he will check and sign off on the fact that these tests have indeed been performed according to code.On August 2, 2011 from 2:30 p.m. to 4:00 p.m. Randy Cesinger tested the first light for 90 minutes, and on August 3, 2011 from 10:30 a.m. to 12:00 the second light was tested for 90 minutes, both according to code. (See attached documents).An inservice is scheduled for August	08/12/2011

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	p.m., the generator test records included spaces for documenting 30 second monthly as well as 1 1/2 hour annual tests for two battery powered emergency lighting fixtures located in the power plant where the emergency generator for the east/west wing was housed. No entry for testing the lighting was entered since August 2010. At the time of record review, the interim administrator called the maintenance office and reported there was no other documentation of testing these light fixtures. 3.1-19(b)			
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 Based on record review and interview, the facility failed to	K0050	We have enabled a monthly computer activiated alert system on the computer of the Manager	08/02/2011

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	ensure fire drills were conducted on every shift during 2 of the past 4 quarters. This deficient practice affects all occupants on the east/west wing. Findings include: Based on a review of monthly Fire Drill Reports for the past year with the environmental services director and interim administrator on 7/22/11 at 1:30 p.m., fire drill documentation was not found for the first shift during the fourth quarter of 2010 or the first, second and third shifts during the first quarter of 2011. The interim administrator said at the time of record review, there had been significant personnel changes and the drills had not been conducted. 3.1-19(b) 3.1-51(c)		of enviromental services and the computer of the office of the Assistant to the Administrator of Providence Health Care. This alert will activate each month on the 5th day of the month at which time the administrator and the manager of environmental services will check the fire drill longs and enusre they are in compliance for the required testings for all three shifts for their quarterly fire drills.In the event that neither of the aforeto mentioned persons would be available on the 5th day of any given month, prior arrangements will be made to forward the alert to an appropriate mangement staff person directly involved with Providence Healt Care and knowledgable of our proceedures for performing a fire drill.When all fire drills have been fully executed on all three shifts the Manager of Environmental services will record said drills in the log book and notify the Administrator.	

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K0051 SS=F	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6 Based on observation and interview, the facility failed to ensure 1 of 3 fire alarm panels in an area not continuously occupied was provided with automatic smoke detection to ensure notification of a fire at the location before it could be incapacitated by fire. NFPA 72, 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in that location. This deficient practice affects all occupants. Findings include:	K0051	We have contacted our fire alarm contractor, Simplex-Grinell, Indianapolis, IN. to come install an automatic smoke detection device in the entry vestibule of the north/south wing of Providence Health Care to ensure notification of a fire before the fire alarm panel which is not continuously occupied and/or monitored could be incapacitated by fire. They are scheduled to do the work on Tuesday, August 9, 2011.Jim Brown, Director of Facilities Maintenance, will monitor the instilation and report to the Administrator when the work is completed.	08/12/2011

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	Based on observation with the environmental services director on 07/22/11 at 2:35 p.m., an ancillary fire alarm control panel (FACP) was located in the entry vestibule of the north/south wing which was not continuously occupied and was not electrically supervised by a smoke detector. The fire panel served a fire system protecting the entire facility. The environmental services director agreed at the time of observation, the panel was not continuously visible to staff. 3.1-19(b)			

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K0074 SS=E	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 18.7.5.1, 1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4, 18.7.5.3 Based on observation and interview, the facility failed to ensure sheer decorative hanging curtains or valances in 33 of 33 east/west resident and activity rooms were rendered flame resistant. LSC 10.3.1 requires draperies, curtains, and other similar loosely hanging furnishings and decorations to have flame resistance as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice affects staff, visitors and 18 residents in the east/west wing.	K0074	As of August 5, 2011 we have been unable to locate the documentation to prove that the material of the sheer decorative hanging curtains or valances is rendered flame resistant. The administrator has made numerous calls to those involved in the renovation of the East/West unit but has been unable to find said documentation. Ace Blind & Drapes, 1621 S. 25th Street, Terre Haute, IN. was contacted for said documentation but Polly Bryan, the person who installed the sheer decorative hanging curtains or valances is on vacation as of the writing of this POC. Therefore the Administrator has ordered the Environmental Services Director to remove all sheer decorative hanging curtains and valances from resident rooms.	08/08/2011

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	Findings include: Based on observations with the environmental services director on 07/22/11 between 11:20 a.m. and 3:20 p.m., windows in the two activity rooms and every resident room had decorative sheer valances and/or sheer curtains. The materials all lacked evidence indicating flame resistance as demonstrated by testing in accordance with NFPA 701. The environmental services director said at the time of observation, there was no evidence the materials were treated to render them flame resistant. 3.1-19(b)		The sheer decorative hanging curtains or valances will be washed, and treated with fire retardant treatment according to code before being rehung.Enviromental Services Director, Dave Kable will supervise the removal of curtains and valances and contact the Administrator when they have been fully removed.	

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K0076 SS=E	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4 Based on observation and interview, the facility failed to ensure 3 of 3 cylinders of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart in the east/west oxygen storage room. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect residents on the east/west wing as well as visitors and 6 staff observed in th service area adjacent to the east/west wing. Findings include: Based on observation with the	K0076	A sign was made and placed on the door of the storage room where the oxygen was improperly stored instructing staff not to store any oxygen in that particular storage room at all. All oxygen has been removed from that room and is now stored on North/South wing of our building in a room where we store all oxygen, which is equipped with holders to properly support and securely store the canisters to prevent them from falling over.An inservice is currently underway for all shifts of nursing personnel on the proper care and storage of oxygen tanks. Jessica Bland, under the direction of Robin Royce, Director of Nursing, is monitoring the inservice which Robin Royce wrote for the staff.	08/12/2011

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	environmental services director on 07/22/11 at 11:50 a.m., three oxygen cylinders stood on a counter top in the east/west clean utility room without support. The environmental services director said at the time of observation the cylinders should have been stored in the racks provided in the oxygen storage room. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on interview and record review, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems for the east/west wing. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA	K0144	While we have been running load tests according to our understanding of the code, and while more than sufficient for the load we pull in our small facility, they are not to the level of testing according to NFPA 110 which states that the load test must be run at 25 % of nameplate for 30 minutes, then at 50% for 30 minutes , followed by 75% for 60 minutes for a total of 2 hours. We have contacted Sycamore Engineering, of Terre Haute, IN., the contractor who performs this test for us, and have reqested that they conduct another load bank test according to NFPA	08/19/2011

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	110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all occupants of the east/west wing. Findings include: Based on review of the Monthly Generator Testing/Inspection records with the environmental services director and interim administrator on 07/22/11 at 2:20 p.m., the generator load on the east/west generator was less than 30 percent of the generator's load capacity during the monthly tests. (The load recorded for June 2011 was 4 percent.) In addition the test was documented: "run time completed: 20 (minutes) and "cool		110. Facilities Maintenance Director, Jim Brown, will oversee this testing proceedure and document that it was tested according to the code requirements. He will also assure that the automated settings for our monthly testing be set so the generators can be exercised monthly for 30 minutes with the available load to meet federal certification and state licensure requirements.The NFPA 110 code for generator testing will be reviewed annually by the Facilities Maintenance Director, and the Health Care Administrator before the annual test is conducted to assure compliance to the code.A reminder to do so will be place on the computer of the Facility Maintenance Diector, the Health Facility Administrator, and the Executive Assistant to the Health Facililty Administrator.	

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	down completed: 10 (minutes)." Asterisks at the bottom of the records noted, "run generator for 30 minutes and then a fifteen (15) minute cool down period." At 3:10 p.m. on 07/22/11, the generator was tested with maintenance # 1 and started within two seconds. Maintenance # 1 said he documented every test of the generator for the facility and records reflected the actual readings. He also said a load test was done by an outside contractor because there was not enough load available to test the generator each month at 30 percent. A review of a load test done by the contractor dated 05/24/11 with the environmental services director and interim administrator on 07/22/11 at 2:10 p.m. noted the east/west generator was tested for 35 minutes under 36 percent load. The environmental services supervisor and interim administrator agreed at the time of review, 36 percent was not enough for a full load test. 3.1-19(b)			

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